DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS

NOTICE OF FINAL RULEMAKING

The Superintendent of Insurance, Insurance Administration, Department of Consumer and Regulatory Affairs (DCRA), pursuant the "Medicare Supplement Insurance Minimum Standards Act of 1992", D.C. Law 9-170 (D.C. Code, Secs. 35-2201 - 35-2209 et seq.), hereby gives notice of the adoption on May 3, 1993 of the following new Chapter 22 Title 26 DCMR, "Insurance". A Notice of Emergency and Proposed Rulemaking was published in the D.C. Register on October 9, 1992 at 39 DCR 7590 - 7657.

Legislation was submitted to the U.S. Department of Health and Human Services, Health Care Finance Administration, and approval was made on July 30, 1992. The Federal standards mandated under Section 1882 of the Social Security Act (Act) as amended by the Omnibus Budget Reconciliation Act of 1990, approved November 5, 1990 (P. L. 101-508) were met.

Pursuant to Section 412 of the District of Columbia Self-Government and Governmental Reorganization Act, P. L. 93-198, "the Act", the Council of the District of Columbia adopted Bill No. 9-459 on first and second readings, June 2, 1992, and July 7, 1992, respectively. Following the signature of the Mayor on July 23, 1992, this legislation was assigned Act No. 9-268, published in the August 7, 1992, edition of the D.C. Register, (Vol. 39 Page 5825) and transmitted to Congress on July 27, 1992 for a 30 day review, in accordance with Section 602(c)(1) of the Act.

A Notice of Final Rulemaking was published in the Register on May 21, 1993 at 40 DCR 3317. The Notice of Final Rulemaking inadvertently omitted certain pages including charts and appendices. The entire text of the Rulemaking is being republished for purposes of clarity.

Chapter 22 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

2200 PURPOSE.

2200.1 The purpose of this chapter is:

(a) To provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

(b) To facilitate public understanding and comparison of such policies;

(c) To eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and

(d) To provide for full disclosure in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

(b) Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

2204.3 **"Benefit Period"**or **"Medicare Benefit Period"** shall not be defined more restrictively than as defined in the Medicare program.

2204.4 **"Convalescent Nursing Home," "Extended Care Facility,"** or **"Skilled Nursing Facility"** shall not be defined more restrictively than as defined in the Medicare program.

2204.5 **"Health Care Expenses"** means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers and such expenses shall not include:

(a) Home office and overhead costs;
(b) Advertising costs;
(c) Commissions and other acquisition costs;
(d) Taxes;
(e) Capital costs;
(f) Administrative costs; and
(g) Claims processing costs.

2204.6 **"Hospital"**may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

2204.7 **"Medicare"** shall be defined in the policy and certificate and may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

2204.8 **"Medicare Eligible Expenses"** shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

2204.9 **"Physician"** shall not be defined more restrictively than as defined in the Medicare program.

2204.10 "Sickness" shall not be defined to be more restrictively than the following:

(a) An illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, and premiums may be modified to correspond with such changes.

(d) A"noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(2) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(e) Except as authorized by the Superintendent, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresenation.

(f) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection 2206.3(h), the issuer shall offer certificateholders an individual Medicare supplement policy and shall offer certificateholders at least the following choices:

(1) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(2) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2207.4 of this chapter.

(g) If membership in a group is terminated, the issuer shall:

(1) Offer the certificateholder such conversion opportunities as are described in paragraph 2206.3(f): or

(2) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(h) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer:

under Part A, subject to the Medicare deductible amount.

2207 **BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 22, 1992.**

2207.1 The standards contained in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in the District of Columbia on or after July 22, 1992.

2207.2 No policy or certificate may be advertised, solicited, delivered or issued for delivery in the District of Columbia as a Medicare supplement policy or certificate unless it complies with these benefit standards.

2207.3 The following General Standards apply to Medicare supplement policies or certificates and are in addition to all other requirements of this chapter.

(a) A Medicare supplement policy or certificate shall not:

(1) Exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition; and

(2) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and premiums may be modified to correspond with such changes.

(d) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(e) Each Medicare supplement policy shall be guaranteed renewable: and

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(h) If such suspension occurs pursuant to paragraph 2207.3(g) and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted, effective as of the date of termination of such entitlement, if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(j) Reinstitution of coverages:

(1) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(2) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(3) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

2207.4 The following standards for Basic ("Core") Benefits, common to all benefit plans, shall apply.

(a) Every issuer;

(1) Shall make available a policy or certificate including only the following Basic "Core" Package of Benefits, common to all benefits plans, to each prospective insured; and

(2) May make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the Basic "Core" Package of Benefits, but not instead of the Basic "Core" package of Benefits.

b) The Basic ("Core") Package of Benefits consists of the following;

(e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(g) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(h) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which are began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000), and for purposes of paragraph 2207.5(h), "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive Medical Care Benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (2) and patient education to address preventive health care measures.

(2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) Fecal occult blood test and/or digital rectal examination;

(B) Mammogram;

(C) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

be considered the insured's place of residence.

(D) **"At-home recovery visit"** means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(2) Coverage Requirements and Limitations.

(A) At-home recovery services provided must be primarily services which assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician and the total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(ii) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(iii) One thousand six hundred dollars ($1,600) per calendar year;

(iv) Seven (7) visits in any one week;

(v) Care furnished on a visiting basis in the insured's home;

(vi) Services provided by a care provider as defined in this section;

(vii) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(viii) At-home recovery visits received

permitted by law.

2208.7 Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits common to all benefit plans, as defined in subsection 2207.4 of this chapter.

(b) Standardized Medicare supplement benefit plan "B" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible as defined in paragraph 2207.5(a).

(c) Standardized Medicare supplement benefit plan "C" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 2207.5(a), (b), (c) and (h) respectively.

(d) Standardized Medicare supplement benefit plan "D" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an Foreign Country and the At-Home Recovery Benefit as defined in paragraphs 2207.5(a) and (b),(h), and (j) respectively.

(e) Standardized Medicare supplement benefit plan "E" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in paragraphs 2207.5(a), (b), (h), and (i) respectively.

(f) Standardized Medicare supplement benefit plan "F" shall

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in paragraphs 2207.5(a), (b), (c), (e), (g), (h), (i), and (j) respectively.

2209 RESERVED

2210 OPEN ENROLLMENT

2210.1 No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale or delivery in the District of Columbia, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual, who is 65 years of age or older, first enrolled for benefits under Medicare Part B.

2210.2 Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under subsection 2210.1 without regard to age.

2210.3 Subsections 2210.1 and 2210.2 shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before it became effective.

2211 STANDARDS FOR CLAIMS PAYMENT.

2211.1 An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(a) Accepting a notice from a Medicare carrier on duly assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

2213 REFUND OR CREDIT OF PREMIUM.

2213.1 An issuer shall collect and file with the Superintendent by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a Standard Medicare Supplement Benefit Plan, described in section 2208 of this chapter.

2213.2 If on the basis of the experience as reported the benchmark loss ratio since inception (ratio 1) exceeds the adjusted experience loss ratio since inception (ratio 3), then a refund or credit calculation is required.

(a) The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan.

(b) For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

2213.4 A refund or credit shall be made only when:

(a) The benchmark loss ratio exceeds the adjusted experience loss ratio; and

(b) The amount to be refunded or credited exceeds a de minimis level.

2213.5 The refund or credit described in subsection 2213.4, shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest of 13 week Treasury notes.

2213.6 A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

2214 ANNUAL FILING OF PREMIUM RATES.

2214.1 An issuer of Medicare supplement policies and certificates issued before or after the effective date of the Medicare Supplement Insurance Minimum Emergency Standards in the District of Columbia shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Superintendent of Insurance in accordance with the filing requirements and procedures prescribed by the Superintendent.

2214.2 The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions,

2215.2 The determination of compliance is made without consideration of any refund or credit for such reporting period.

2215.3 Public notice of such hearing shall be furnished in a manner deemed appropriate by the Superintendent.

2216 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

2216.1 An issuer shall not:

(a) Deliver or issue for delivery a policy or certificate to a resident of the District of Columbia unless the policy form or certificate form has been filed with and approved by the Superintendent of Insurance in accordance with filing requirements and procedures prescribed by the Superintendent; and

(b) Use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Superintendent of Insurance in accordance with the filing requirements and procuedures prescribed by the Superintendent.

2216.2 Except as provided in subsection 2216.3, an issuer shall not file for approval more than one form of a policy or certificate of each type for each Standard Medicare Supplement Benefit Plan described in section 2208.

2216.3 An issuer may offer, with the approval of the Superintendent, up to four (4) additional policy forms or certificate forms of the same type for the same Standard Medicare Supplement Benefit Plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage; and

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

2216.4 For the purposes of section 2216, a "type" means an individual policy or a group policy.

2216.5 Except as provided in subsections 2216.7 and 2216.8, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this chapter that has been approved by the Superintendent.

shall be combined for purposes of the refund or credit calculation prescribed in section 2213.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

2217 PERMITTED COMPENSATION ARRANGEMENTS

2217.1 An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

2217.2 The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

2217.3 No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

2217.4 For purposes of section 2217 **"compensation"** includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

2218 REQUIRED DISCLOSURE PROVISIONS – GENERAL RULES.

2218.1 Medicare supplement policies and certificates shall:

include a renewal or continuation provision and the language or specifications of such provision shall be consistent with the type of contract issued.

2218.2 The renewal or continuation provision shall:

(a) Be appropriately captioned;

(b) Appear on the first page of the policy; and

(c) Include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2218.3 Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required

the policy is delivered.

2219 **REQUIRED DISCLOSURE PROVISIONS – NOTICE REQUIREMENT.**

2219.1 As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Superintendent.

2219.2 Notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) Inform each policyholder or certificateholder as to when any premium adjustments is to be made due to changes in Medicare.

2219.3 The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

2219.4 Such notices shall not contain or be accompanied by any solicitation.

2220 **REQUIRED DISCLOSURE PROVISIONS – OUTLINE OF COVERAGE REQUIREMENTS FOR MEDICARE SUPPLEMENT POLICIES.**

2220.1 Issuers shall:

(a) Provide an outline of coverage to all applicants at the time application is presented to the prospective applicant; and,

(b) Except for direct response policies, obtain an acknowledgment of receipt of such outline from the applicant; and

2220.2 If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall:

(a) Accompany such policy or certificate when it is delivered and

(b) Contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

[COMPANY NAME]

Outline of Medicare Supplement Coverage—Cover Page.
Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)
				Preventive Care					Preventive Care

information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this chapter. An issuer may use additional benefit plan designations on these charts pursuant to Subsection 2208.6 of this chapter.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Superintendent.]

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All Costs

PLAN F

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN H

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J (continued)

PARTS A & B (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare.			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

if requested within 90 days of losing Medicaid eligibility.

(4) Counseling services may be available in the District of Columbia to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

(b) **[Questions]** To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

(A) If so, with which company?

(2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

(A) If so, with which company?

(B) What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you

intend to replace these medical or health policies with this policy [certificate]?

(4) Are you covered by Medicaid?

2222.3 Agents shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

(b) List policies sold in the past five (5) years which are no longer in force.

2222.4 In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

2222.5 Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage.

(a) One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed

probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

_____

(Date)

*Signature not required for direct response sales.

2222.7 Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

2223 **FILING REQUIREMENTS FOR ADVERTISING.**

2223.1 An issuer shall provide a copy of any Medicare supplement advertisement intended for use in the District of Columbia whether through written, radio or television medium to the Superintendent of Insurance for review or approval by the Superintendent to the extent it may be required under District of Columbia law.

2224 **STANDARDS FOR MARKETING**

2224.1 An issuer, directly or through its producers, shall:

2225.2 Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

2226 **REPORTING OF MULTIPLE POLICIES.**

2226.1 On or before March 1 of each year, an issuer shall report the following information for every individual resident of the District of Columbia for which the issuer has in force more than one Medicare supplement policy or certificate:

(a) Policy and certificate number, and

(b) Date of issuance.

2226.2 The items set forth above must be grouped by individual policyholder.

2226.3 Appendix B contains a reporting form for compliance with this section.

2227 **PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.**

2227.1 If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

2227.2 If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisiting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

2228 **EFFECTIVE DATE.**

This chapter was adopted on October 1, 1992.

2299 **DEFINITIONS.**

2299.1 For purposes of this chapter, the words and phrases set forth in this section shall have the meanings ascribed.

Applicant

(a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w)_____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

line		(a) Earned Premium (x)	(b) Incurred Claims(y)
1	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues (z)		
	c. Net (for reporting purposes = 1a - 1b)	_____	_____
2	Past Years' Experience (All Policy Years)	_____	_____
3	Total Experience (Net Current Year + Past Years' Experience)	_____	_____
4	Refunds last year (Excluding Interest)		
5	Previous Since Inception (Excluding Interest)		
6	Refunds Since Inception (Excluding Interest)		
7	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		
8	Experienced Ratio Since Inception		
	Total Actual Incurred Claims (line 3, col b) / Tot. Earned Prem.(line 3, col a) - Refunds Since Inception(line 6) = Ratio 2		
9	Life Years Exposed Since Inception _____		

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) _____

APPENDIX B

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date